

GROUND AMBULANCE

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid.

Ground ambulances must be licensed by the Department of Health under [ARSD Ch. 44:05:04](#). Out of state providers must be licensed and enrolled with their home state's Medicaid agency.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's [online portal](#).

The following recipients are eligible for medically necessary services covered in accordance with the limitation described in this chapter and in the table below:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Medicaid – Pregnancy Related Postpartum Care Only (47)	Coverage restricted to family planning and postpartum care only.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to co-payments and deductibles for Medicare Part A and Part B covered services.
Medicaid – Pregnancy Related Coverage Only (77)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.

Refer to the [Recipient Eligibility](#) manual for additional information regarding eligibility.

COVERED SERVICES AND LIMITS

Ground ambulance services are limited to transporting a recipient locally or to the nearest medical provider that is equipped or trained to provide the necessary service. Ambulance services are only billable if the recipient is transported. The following services are eligible for payment when provided by an enrolled ambulance provider:

- Ground ambulance services to or from a medical provider, or between medical facilities when other means of transportation would endanger the life or health of the recipient;
- Services of additional attendants when medically necessary;
- Oxygen provided during transit;
- Loaded mileage. Mileage may not be billed for more than one patient per trip; and
- Other ambulance services listed on the department's [transportation fee schedule](#).

Basic Life Support (BLS)

Services are reimbursable at a BLS level when services provided include basic, non-invasive interventions to reduce the morbidity and mortality associated with a medical response including those procedures described in [ARSD 44:05:03:05.04](#) and [44:05:03:05.08](#). Nebulizer treatment is considered a BLS level procedure.

In addition, transportation of a recipient to or from the air transport with the air transport team is considered a BLS service.

Advanced Life Support (ALS)

Services are reimbursable at an ALS level when performed by advanced life support personnel licensed under [SDCL Ch. 36-4B](#) and the services consist of basic life support procedures plus at least one advanced service, including but not limited to, invasive procedures such as intravenous cannulation, shock management, manual defibrillation, telemetered electrocardiography, administration of cardiac drugs, administration of specific medications and solutions, use of adjunctive breathing devices, advanced trauma care, tracheotomy suction, esophageal airways and endotracheal intubation, intraosseous infusion, or other advanced skills approved by the South Dakota Board of Medical and Osteopathic Examiners.

Emergent Ground Ambulance Services

Ground ambulance services are considered emergent when the recipient is suffering from an illness or injury and other means of transportation threaten the life or health of the recipient.

Examples of medically necessary emergent ground ambulance services include:

- The recipient was transported in an emergency situation as a result of an accident, injury, or acute illness;
- The recipient required oxygen as emergency treatment or the recipient required other emergency treatment during transport to the nearest facility;
- The recipient was unconscious or in shock;
- The recipient exhibited signs and symptoms of acute respiratory distress or cardiac distress such as shortness of breath or chest pain;
- The recipient exhibited signs and symptoms that indicate the possibility of acute stroke;
- The recipient needed to remain immobile because of a fracture that had not been set or the possibility of a fracture; or
- The recipient experienced severe hemorrhage.

Non-Emergent Ground Ambulance Services

Non-emergent ambulance services are reimbursable in the following situations:

- The recipient is confined to a bed and it is documented by a physician or other licensed practitioner that other means of transportation including secure medical transportation, such as stretcher van, are contraindicated; or
- The recipient's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

A recipient is considered confined to a bed when the following criteria are met:

- The recipient is unable to get up from bed without assistance;
- The recipient is unable to ambulate; and
- The recipient is unable to sit in a chair or wheelchair.

For transports not meeting the above requirements, ground ambulance providers may enroll as a secure medical transportation provider and may bill secure medical transportation services using the secure medical transportation codes on the department's fee schedule. In order to bill ground ambulance for non-emergent services, the provider must identify alternative secure medical transportation and document in the medical record the reason alternative transportation is not feasible for the transport of the recipient. Documentation must support [medical necessity](#) of the transport. A list of secure medical transportation providers is available on the Department's [website](#).

NON-COVERED SERVICES

Services not specifically listed in the covered services section are considered non-covered.

DOCUMENTATION REQUIREMENTS

Record Retention

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Records must not be destroyed when an audit or investigation is pending. Per [ARSD 67:16:01:08](#) health services that are not documented are not covered. Providers must grant access to these records to agencies involved in a Medicaid review or investigation.

Ground Ambulance Documentation Requirements

Return trips or other non-emergency trips by ground ambulance must be justified by a physician or other licensed practitioner's order. Documentation of the order must exist in the provider's file, but is not required to be submitted with the claim for payment. If a ground ambulance transports a recipient to a

provider other than the closest provider, the provider must document that a physician or other licensed practitioner directed them to another provider.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid if one or more of the following situations exist:

- The claim is an adjustment or void of a previously paid claim and is received within 3 months after the previously paid claim;
- The claim is received within 6 months after a retroactive initial eligibility determination was made as a result of an appeal;
- The claim is received within 3 months after a previously denied claim;
- The claim is received within 6 months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or
- To correct an error made by the department.

Third-Party Liability

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is the payer of last resort, meaning Medicaid only pays for a service if there are no other liable third-party payers. There are a few exceptions to this rule, such as services provided by Indian Health Services.

Providers must pursue the availability of third-party payment sources. Third-party liability (TPL) is the legal obligation of a third party to pay for all or part of a recipient's medical cost. Third-party payers include private health insurance, worker's compensation, disability insurance, and automobile insurance. Medicare is primary to South Dakota Medicaid and must be billed first. Any balance after Medicare payment should be billed to other TPL payers prior to billing Medicaid.

Providers should use the [Medicare Crossover billing instructions](#) if the recipient has Medicare coverage and the [Third-Party Liability billing instructions](#) for all other instances of third party liability.

Reimbursement

The rate of payment for ground ambulance service is the base fee, loaded mileage, and other medically necessary covered services. Payment is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's fee schedule [website](#).

Claim Instructions

- A claim for ground ambulance transportation service must be submitted at the provider's usual and customary charge.
- A claim for ground ambulance service may contain only ground ambulance procedure codes found on the department's [transportation fee schedule](#).
- A claim must include the point of origin and destination of the recipient being transported.
- A provider may not bill for any portion of ambulance service during which the recipient was not physically present in the ambulance.
- Mileage units must be rounded to the nearest whole mile. A provider may bill for services only if a recipient was actually transported.
- Charges for transporting the recipient from the airport to the hospital or from the hospital to the airport must be billed by the ground ambulance provider and may not be included in the air ambulance charge.
- When applicable, the TK modifier, which indicates an additional South Dakota Medicaid recipient is being transported, must be included on a provider's claim. Modifier payment effects are described on the department's [website](#).
- Applicable descriptive modifiers are required to be included on the claim.

DEFINITIONS

1. "Ambulance provider," a company, firm, or individual licensed by the Department of Health under the provisions of [article 44:05](#) to provide ambulance services or, if based out of state, a company, firm, or individual which provides ambulance services and is a participating Medicaid provider in the state where it is located;
2. "Ground ambulance," a motor vehicle licensed by the Department of Health under [chapter 44:05:04](#) and used to respond to medical emergencies; and
3. "Loaded mileage," mileage driven or flown while a patient is being transported.

REFERENCES

- [Administrative Rule of South Dakota \(ARSD\)](#)
- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)

FREQUENTLY ASKED QUESTIONS

1. **Does Medicaid pay for ambulance services when an ambulance is called and responds, but the recipient is not transported?**

No, this is not a covered service per [ARSD 67:16:25:02](#).

- 2. Does Medicaid pay for a recipient to be transported to the hospital/health care facility of their choice?**

No.

- 3. May a Medicaid recipient be billed for mileage if the recipient requests transportation to a specific hospital other than the closest provider?**

No, South Dakota Medicaid's rules state that providers may not bill a recipient once they have billed Medicaid for the service; Medicaid payment is considered payment in full. An ambulance provider could receive reimbursement to another hospital if the provider obtains specific documentation from the physician regarding the medical necessity of a recipient travelling to a specific hospital in place of the closest hospital. The documentation should be retained in the recipient's medical record.

- 4. May an ambulance provider bill for Secure Medical Transportation when the service does not meet the requirements for non-emergent ambulance transport?**

Yes, an ambulance provider may enroll as a secure medical transportation provider and bill for services at the secure medical transportation provider rates.

- 5. What documentation is required when an ambulance provider is diverted from a closest hospital to another hospital?**

The provider should note the diversion in their trip report and obtain documentation from the hospital regarding the diversion. A fax or letter from the hospital stating the diversion and reason for the diversion for the specific trip should be retained in the recipient's medical record.